STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154050	A. BUILDING 01 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHEASTERN CENTER	1850 WESLEY RD AUBURN, IN46706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 482.41(b). Survey Date: 06/20/11 Facility Number: 003734 Provider Number: 154050 AIM Number: 200404950A Surveyors: Amy Kelley, Life Safety Code Specialist. At this Life Safety Code survey, Northeastern Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	alarm system with smoke detection in the corridors, spaces open to the corridors and patients rooms. The facility has a capacity of 16 and had a census of 6 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/23/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 storage rooms with combustibles, measuring over 50 square feet in	K0029	Facility has corrected the clean utility room with self closing door as of 7/7/11 and it is fully operational.Person Responsible: Maintenance	07/07/2011

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	size, was provided with a self closing device. This deficient practice could affect four patients. Findings include: Based on observation with the Maintenance Coordinator and the Maintenance Foreman on 06/20/11 at 1:22 p.m., the corridor door to the clean utility room, measuring over 50 square feet in size, containing linen and blankets lacked a self closing device. This was confirmed by the Maintenance Foreman at the time of observation.			
K0048	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of alarms and transmission of alarms to the fire department in the written plan for the protection of 6 of 6 patients and for their evacuation in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the	K0048	FAcility policy and procedure will be revised to reflect RACE (Rescue, activate alarm, confine the fire, evacuate/extinguish) and will train all staff of the same. Responsible Person: Risk Managment Nurse	08/01/2011

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	following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all patients in the facility. Findings include: Based on a review of the facility's written fire disaster plan titled "Emergency Fire Evacuation Plan" with the Maintenance Coordinator, Maintenance Foreman and the Assistant Director of Nursing (ADON) on 06/20/11 at 11:25 a.m., the fire plan did not address the use of alarms and the transmission of alarm to the fire department. This was acknowledged by the ADON at the time of record review.			

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K0050	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on review of the "Fire Drill Report Form" with the Maintenance Coordinator and the Maintenance Foreman on 06/20/11 at 12:25 p.m., there was no record of a third shift fire drill for the third quarter of 2010. Based on an interview with the Maintenance Foreman at the time of record review, no other documentation was available for review to verify this drill was conducted.	K0050	Fire drill procedures will be revised to ensure fire drills occur at unexpected times on a quarterly basis on EACH shift (1st, 2nd, 3rd). All staff will be updated and trained on this in addition training on the use of the forms specific to fire drills will be reviewed with staff to adhere to compliance of the ISDH Life Safety regulations. Responsible Person: Risk Managment Nurse/Maintenance Coordinator	07/20/2011

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K0051	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors in the 200 hall medical supply room was installed where air flow would not adversely affect their operation. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors	K0051	The fire alarm system was completed with the approved components according to NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of hte building as noted of need specific to the 200 and 100 hall of the hospital. Responsible Person: Maintenance	07/20/2011

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	shall not be located where air flow prevents operation of the detectors. This deficient practice could affect four patients on the 100 hall. Findings include: Based on an observation with the Maintenance Coordinator and the Maintenance Foreman on 06/20/11 at 1:21 p.m., the smoke detector in the 200 hall medical supply room was located within three feet of an air supply duct. This was acknowledged by the Maintenance Foreman at the time of observation.			
K0052	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard.	K0052	The fire alarm system required for life safety will be installed, tested and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. Staff will be trained and updated on this procedure. Responsible Person: Maintenance/Risk Management	07/20/2011

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	NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants. Findings include: Based on an observation with Maintenance Coordinator, Maintenance Foreman and Assistant Director of Nursing (ADON) on 06/20/11 at 2:10 p.m., when the automatic dialer component was placed in trouble from phone line failure for five minutes no local trouble alarm was initiated. The trouble signal was not transmitted to the annunciator panel at the main entrance or the main fire alarm panel located in the electrical room. This was confirmed by Maintenance Foreman at the time of observation.			
K0067	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2			

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	Based on observation and interview, the facility failed to ensure 21 of 21 smoke/fire dampers throughout the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. A CMS waiver for hospitals requires at least every 6 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all occupants. Findings include: Based on observation with the Maintenance Foreman on 06/20/11 at 1:05 p.m., fire dampers were observed while in the mezzanine. Based on interview with the Maintenance Coordinator and the Maintenance	K0067	Procedures will be updated to include the heating, ventilating and air conditioning will comply with the provision of Section 9.2 referencing of facilities 21 smoke/fire dampers throughout the facility where inspetions are compliant every four years in accorance with NFPA 90A. LSC9.2.1. Maintenance is currently working with Service Mechanical for location of report indicating compliance.Responsible Person: Maintenance	07/20/2011

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	Foreman, fire/smoke dampers were located throughout the facility. Based on interview with the Maintenance Foreman at 2:50 p.m. on 06/20/11, documentation stating the fire/smoke dampers have received an inspection was not available for review.			
K0070	Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 Based on observation and interview, the facility failed to have a policy for the use of 2 of 2 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice was not in a patient care area but could affect any number of staff. Findings include: Based on observations with the Maintenance Coordinator, the Maintenance Foreman and the Assistant Director of Nursing (ADON) on 06/20/11 from 12:20 p.m. to 1:16 p.m., there was a space heater at the desk of the	K0070	Facility policy and procedure will be revised to reflect portable space heating devices in employee work areas. Staff will be trained accordingly to revision of policy. Devices will be inspected by maintenance and tagged accordingly. Policy and devices will comply with NFPA 101 Section 19.7.8Responsible Person: Risk Managment Nurse Maintenance / Hospital Director	07/20/2011

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	state liaison in the administration area and in the doctor's office. The space heaters were not in use at this time. Based on interview with the ADON at 2:40 p.m., the facility did not have a policy regarding the use of space heaters.			
K0144	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:	K0144	Facility procedures will be follwed reflecting generator inspections weekly and exercised under load for 30-minutes per month in accorance with NFPA99 3.4.4.1 ith an alarm annunciater in a location readily observed by operating personnel at a regular work station, such as the nurse's station. Written records will be kep current and completed monthly acocording to NFPA 99, NFPA 110RESPONSIBLE PERSON: mAINTENANCE	07/20/2011

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	(a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all occupants. Findings include:			

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	Based on an observation with Maintenance Coordinator and the Maintenance Foreman on 06/20/11 at 1:10 p.m., the emergency generator did not have a remote annunciator panel. Based on an interview with the Maintenance Foreman at the time of observation, he was not aware of this requirement. 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 11 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of			

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	NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on review of the generator log "Weekly Preventative Maintenance for Standby Generator" with the Maintenance Coordinator and the Maintenance Foreman on 06/20/11 at 12:40 p.m., the only documentation of a generator load test was March 2011. Based on an interview with the Maintenance Foreman at the time of record review, no other documentation was available for review. Additionally, the generator log did not indicate whether the generator was exercised under operating conditions or not less than 30 percent of the EPS nameplate rating.			

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K0154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to protect 6 of 6 patients by providing a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for more than 4 hours in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-2 requires an appointed sprinkler impairment coordinator. NFPA 25, 11-5 requires a preplanned program to include evacuation or an approved fire watch and 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance	K0154	Facility policies and procedures will be updated / revised to be in compliance with NFPA 25, section 9.7.6.1 and 9.7.6.2 (11-5 (d-f)) and 11-7. Adding 15-minute interval check and notification to the ISDH, should the sprinkler system be impaired for four hours or more within a 24 hour period. Staff will be trained and updated on policy and procedure. Responsible Person: Risk Management	07/20/2011

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	carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified and 11-5(f) requires notification of supervisors in the area in addition to those already mentioned and lastly 11-7 requires notification of everyone again when the system is restored. This deficient practice could affect all occupants. Findings include: Based on review of the "Fire Watch Inspection Program" policy with the Maintenance Coordinator, the Maintenance Foreman and the Assistant Director of Nursing (ADON) on 06/20/11 at 11:34 p.m., the facility did have a written policy and procedure for an impaired sprinkler system available for review, but it did not address the following: a) the designated person(s) shall have not other duties or responsibilities b) the Indiana State Department of Health must be notified c) the local fire department must be notified Based on interview with the ADON			

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	154050	A. BUILDING 01 B. WING	06/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHEASTERN CENTER	1850 WESLEY RD AUBURN, IN46706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at the time of record review, it was acknowledged the fire watch policy did not include the aforementioned items.			
K0155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a complete written policy for the protection of 6 of 6 patients indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through	K0155	Facility Policies and Procedures will be revised to comply with LSC 9.6.1.8 LSC 19.7.1.1. Specifically relating to accountability for 15-minute interval checks, designated person, and notification to the ISDH and the local fire department, should the fire alarm system be impaired for four hours or more within a 24 hou period. Staff will e trained and updated on policy and procedure.Responsible Person: Risk Management.	07/20/2011

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	19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affect all occupants. Findings include: Based on review of the "Fire Watch Inspection Program" policy with the Maintenance Coordinator, the Maintenance Foreman and the Assistant Director of Nursing (ADON) on 06/20/11 at 11:34 a.m., the facility did have a written policy and procedure for an impaired fire alarm system available for review, but it did not address the following: a) the designated person(s) shall have not other duties or responsibilities b) the Indiana State Department of Health must be notified c) the local fire department must be notified			

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	Based on interview with ADON at the time of record review, it was acknowledged the fire watch policy did not include the aforementioned items.			
K0211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 Based on observation and interview, the facility failed to ensure 2 of 2 alcohol based hand sanitizers in the Assistant Director of Nursing's (ADON) office and the doctor's office were not installed above or near an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be maintained	K0211	Facility shall relocate ABHR (Alcohol Based Hand Rub) dispensers so that they are in compliance with NFPA 101 in 19.1.1.3 where they are located or installed above or near an ignition source and relaocate them in accordance to code.Responsible Person: Maintenance	07/07/2011

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	and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice was not in a patient care area but could affect any number of staff. Findings include: Based on observations with the Maintenance Coordinator, the Maintenance Foreman and the ADON on 06/20/11 from 1:00 p.m. to 1:15 p.m., alcohol based hand sanitizer dispensers were mounted on the wall above a light switch in the ADON's office and above a light switch in the doctor's office. This was acknowledged by the Maintenance Foreman at the time of the observations.			